



MEDI-CAL CHOICE FORM

Use this form to join or change health plans. If you need help filling out this form, call 1-800-430-4263.

Mail Completed form to: California Department of Health Care Services • Health Care Options • Box 989009, W. Sacramento, CA 95798-9850.

PLEASE PRINT CLEARLY USING BLUE OR BLACK INK ONLY. COMPLETELY FILL IN THE OVALS ☐ TO INDICATE YOUR CHOICE. SEE BACK FOR EXAMPLE

| | | |
|------------------------------------------------------------------------------|--------|----------------------|
| <input type="radio"/> M <input type="radio"/> F | | <input type="text"/> |
| 1) Head of Household Name (First Name, Last Name) | 2) Sex | 3) Telephone Number |
| <input type="text"/> | | |
| 4) Home Address (House Number, Street, Apartment Number, City, and Zip Code) | | |

Please choose a Health Plan from the list for each member listed. The Doctor/Clinic Codes can be found in the Health Plan Provider Directory.

| | | | |
|---------------------------------------------------------------------------------------------------------|--------|----------------------------|----------------------------|
| <input type="radio"/> M <input type="radio"/> F | | <input type="text"/> | <input type="text"/> |
| 5) Applicant's Name (First Name, Last Name) | 6) Sex | 6a) Due Date (if pregnant) | 6b) Social Security Number |
| <input type="radio"/> I wish to JOIN or change my plan to: | | | |
| <input type="radio"/> 131 Molina Healthcare Partner <input type="radio"/> 167 Care1st Partner Plan, LLC | | | |
| <input type="radio"/> 029 Community Hlth Grp Partner <input type="radio"/> 000 Regular Medi-Cal (FFS) | | | |
| <input type="radio"/> 068 Health Net Comm Solutions | | | |
| <input type="radio"/> 079 KP Cal, LLC | | | |
| Doctor/Clinic Code <input type="text"/> | | | |
| Enter plan change reason code* <input type="checkbox"/> | | | |

| | | | |
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| <input type="radio"/> M <input type="radio"/> F | | <input type="text"/> | <input type="text"/> |
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| Doctor/Clinic Code <input type="text"/> | | | |
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| | | | |
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| <input type="radio"/> 068 Health Net Comm Solutions | | | |
| <input type="radio"/> 079 KP Cal, LLC | | | |
| Doctor/Clinic Code <input type="text"/> | | | |
| Enter plan change reason code* <input type="checkbox"/> | | | |

*PLAN CHANGE REASON CODES:

Code 1: I could not choose the doctor or dentist I wanted

Code 2: The health/dental plan did not meet my needs

Code 3: My doctor/dentist did not meet my needs

Code 4: Too far to go

Code 5: I did not choose this plan

Code 6: Moving out of the county

Code 7: Indian Health Program Exemption

Code 8: Medical/Dental Exemption

Code 9: Other

NOTICE: I have read the plan description. I understand that Kaiser requires the use of binding neutral arbitration to resolve certain disputes. This includes disputes about whether the right medical treatment was provided (called medical malpractice) and other disputes relating to benefits or the delivery of services. If I pick Kaiser, I give up my right to a jury or court trial for those certain disputes. I also agree to use binding neutral arbitration to resolve those certain disputes. I do not give up my right to a State hearing of any issue, which is subject to the State hearing process.

CHOICE STATEMENT: I/We have made written choice to receive Medi-Cal benefits through the medical plans as I/we have indicated on this form. I/We have read and understand the conditions of this agreement. I/We understand that in order to change my/our current Medi-Cal Health plan, I/we must complete this form.

Head of Household's Signature

Date

Other Adult's Signature

Date

Other Adult's Signature

Date

7254061943

Highly Confidential



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